


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/17/2018
FORM APPROVED
OMB NO. 0938-0391

| | | | | |
|--|---|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G118 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 10/16/2018 |
| NAME OF PROVIDER OR SUPPLIER SHANNONBROOK HOME | | | STREET ADDRESS, CITY, STATE, ZIP CODE 914 WEST FIRST STREET NEWTON, NC 28658 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| W 249 | <p>PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1)</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure 1 of 3 sampled clients (#2) received a continuous active treatment program consisting of needed interventions in sufficient number and frequency related to communication, to support the person centered plan (PCP). The finding is:</p> <p>Observations in the group home throughout the 10/15/18 - 10/16/18 survey revealed client #2 to be non-verbal. Staff member were observed prompting the client verbally, gesturally and physically. No communication aides were used. Examples of prompted activities included: games; toileting; getting on the van for an outing; dining; preparing drinks; and medication administration. Further observations in the group home revealed pictures and symbols posted throughout the home including: games/toys; a medication bubble pack; van; cup; plate; and toilet.</p> <p>Review of the record for client #2 on 10/16/18 revealed a PCP dated 3/27/18. The PCP included a section titled "Rules of Interaction". These directions for client communication</p> | W 249 | <p>W 249 - See below for corrections.</p>  <p>W 249 - Habilitation Specialist will implement formal communication program. In addition, Habilitation Specialist will ensure all staff are trained/inservised on correct implementation of program. Proper implementation will be monitored through weekly interaction assessments conducted by the interdisciplinary team.</p> <p>In the future, QIDP and Habilitation Specialist will ensure all staff are trained/inservised on all communication objectives for the individuals supported.</p> | 12/14/18 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



Program Director

10/24/18

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/17/2018
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G118 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 10/16/2018 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER SHANNONBROOK HOME | | | STREET ADDRESS, CITY, STATE, ZIP CODE 914 WEST FIRST STREET NEWTON, NC 28658 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| W 249 | Continued From page 1 indicated the need for visual supports to aide in understanding, and instructed the use of gestures, objects, photographs and line drawing symbols in all communication exchanges. The section also indicated that objects and symbols had the most chance of success. Continued review of the PCP revealed a communication assessment dated 3/21/18 which indicated the continued need of visual supports to aid in understanding. Interview with the qualified intellectual disabilities professional and the habilitation specialist on 10/16/18 confirmed that client #2's communication needs include the use of pictures, symbols and objects and confirmed staff should have been using the communication aides that were available in the group home. | W 249 | | | |